IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 28, 2006

Michelle Parker, Administrator
Preferred Community Homes – Sunset Oaks
440 W Pennwood Ste 200
Meridian, ID 83642

RE: Preferred Community Homes – Sunset Oaks, Provider # 13G052

Dear Ms Parker:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded at your facility, Preferred Community Homes - Sunset, on July 10 to July 12, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 11, 2006**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G052	A. BUILDING _____ B. WING _____	07/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - SUNSET	7591 BIRCH LANE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Monica Williams, QMRP, Team Leader Sherri Case, LSW, QMRP Common abbreviations used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional	W 000	Preparation and implementation of this plan of corrections does not constitute admission or agreement by Sunset Oaks with the facts, findings, or other statements as alleged by the State agency dated July 12, 2006. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Sunset Oaks specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on staff and individual interviews, it was determined the facility failed to ensure individuals had free access to their own possessions which meet their needs, interests, and choices for 1 of 1 individual (Individual #1)whose Game Boy was reported to have been taken from her. This resulted in an individual not having access to her personal possession. The findings include: Eight direct care staff and two individuals were interviewed on 7/11/06 from 1:35 - 4:15 p.m. At 1:40 p.m., Individual #3 was asked if anyone had ever taken someone's possessions and hid them. He stated it had not happened to him but a staff person had taken Individual #1's Game Boy from her. When asked, he stated he did not remember the name of the staff or when it happened.	W 137	**W137 483.420(a)(12) PROTECTION OF CLIENT RIGHTS** Sunset Oaks staff training completed on client rights and Administrator notification. The individuals living at Sunset Oaks received training on their rights with the right to personal belongings focused on strongly. Staff and residents will receive training at least quarterly on resident rights. Completion date 07-01-2006 Person Responsible: AQMRP/ Administrator Monitoring: At least quarterly RECEIVED AUG 0 9 2006 BUREAU OF FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Parker, Admin		8-4-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o[illegible] safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days f[illegible]ing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G052	A. BUILDING _____ B. WING _____	07/12/2006

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - SUNSET	7591 BIRCH LANE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 137	Continued From page 1 One direct care staff stated, on 7/11/06 at 2:31 p.m., that about a month ago, Individual #1's Game Boy was taken from her and hidden by another direct care staff. The staff person did not know the name of the staff person who had taken the game but knew that it occurred because when she reported to work the following morning, she could not find it and was told the game was on top of a kitchen cabinet. The AQMRP, who was present during the interviews, stated it was probably taken in order to get Individual #1 to comply and she would not do anything when she had it. During an interview on 7/12/06 from 9:50 - 10:50 a.m., the Administrator stated she had not been informed of the incident. During the exit conference on 7/12/06 from 1:00 - 2:00 p.m., the Administrator stated an investigation was initiated after the above noted interview and Individual #1's guardian was notified at approximately 11:00 a.m. The Administrator stated she interviewed Individual #3 and the staff person who found the Game Boy. The Administrator stated Individual #3 told her a staff person on the graveyard shift had taken the Game Boy and the staff person told her the Game Boy was hidden on top of a kitchen cabinet, behind the plants. The facility failed to ensure Individual #1 had free access to her Game Boy.	W 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G052	A. BUILDING _____ B. WING _____	07/12/2006

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - SUNSET	7591 BIRCH LANE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of as-worked schedules and staff interviews, it was determined the facility failed to ensure potential neglect was prevented while an investigation of neglect was in process for 1 of 7 individuals (Individual #2) residing in the facility. This resulted in the potential for an individual to be subjected to ongoing neglect during the course of an investigation. The findings include: Eight direct care staff and two individuals were interviewed on 7/11/06 from 1:35 - 4:15 p.m. At 3:45 p.m., a direct care staff stated that on 7/9/06 at 8:45 p.m., she reported to the AQMRP that Individual #2 had not had her Attends (adult brief) changed for 7 hours. The staff stated when she reported to work on 7/9/06 at 8:30 p.m., she checked Individual #2's Attends and noticed they had not been changed since 1:30 p.m. as a staff had written on the Attends the time it was last changed. The staff stated she reported the incident and it was considered neglect if individuals' Attends were not changed as scheduled. The AQMRP, who was present during the 7/11/06 interviews, stated the incident was reported and was in process of being investigated. The AQMRP stated individuals' Attends were to be checked every two hours and if they were not soiled, they could be worn another two hours. The AQMRP stated individuals' Attends were to be changed every four hours whether they were wet or dry.	W 155	**W155 483.420(d)(3) STAFF TREATMENT OF CLIENTS** Staff training on reporting to the correct person (Administrator) of any potential neglect or abuse. Administrative training received to ensure staff suspension policy followed during an investigation. All investigations are sent to Westcare for tracking and monitoring and quality assurance. Completion date 07-21-2006 Person Responsible: Administrator Monitoring: Daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G052	A. BUILDING _____ B. WING _____	07/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - SUNSET	7591 BIRCH LANE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	Continued From page 3 When asked about writing on individuals' Attends, the Administrator who was an LPN, stated on 7/12/06 at 10:45 a.m., it was taught in nursing school and was a standard nursing practice. A second LPN was interviewed on 7/12/06 at 11:00 a.m. and she stated it was taught in nursing school and was standard nursing practice. The as-worked schedule, dated 7/9/06, documented the staff who had not changed Individual #2's Attends completed the shift at 10:00 p.m. The as-worked schedule, dated 7/10/06, documented the staff who had not changed Individual #2's Attends worked from 2:00 p.m. until 10:00 p.m. When asked, the Administrator and AQMRP stated during an interview on 7/12/06 from 9:50 - 10:50 a.m., the staff person was not put on leave. The facility failed to ensure Individual #2 was protected from further potential neglect while the investigation was in process.	W 155		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G052	A. BUILDING _____ B. WING _____	07/12/2006

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - SUNSET	7591 BIRCH LANE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W155.	MM177	**MM177 16.03.11.075.09 Protection from Abuse and Restraint** **Please refer to W155**	
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	**MM209 16.03.11.075.15 Rights to Personal Items** **Please refer to W137.**	

Bureau of Facility Standards M. Parker, Admin 8-4-06

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE